N441 Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission	**Patient Initials**	**Age**	**Gender**
10/29/2021	D.T.	87 years old	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White/Caucasian	Retired	Married	Cephalexin – Rash and Shortness of breath
Code Status	**Height**	**Weight**	
FULL Code	5’9” (175.3 cm)	83.1 kg (183 lbs. 4.8 oz)	

Medical History (5 Points)

Past Medical History: The patient has a history of chronic systolic heart failure, chronic obstructive pulmonary disease, benign prostatic hyperplasia (BPH), hypertension (HTN), arteriosclerotic heart disease, gastroesophageal reflux disease (GERD), sleep apnea; atrial fibrillation; and complete heart block treated with a permanent pacemaker.

Past Surgical History: The patient had bunionectomy, bilateral carpal tunnel release, back surgery, hernia repair, coronary angioplasty with stent placement (2019), insertion of pacemaker (2019), bladder tumor excision (2021), upper GI endoscopy (2021), colonoscopy (2021), chest tube insertion (2021), and left femur fracture surgery (2021).

Family History: The patient’s father had COPD.

Social History (tobacco/alcohol/drugs): The patient denies any past or current tobacco and smokeless tobacco use. Patient denies current alcohol consumption. Patient denies any use recreational drug or substance use.

Assistive Devices: The patient has a walker and wears hearing aids.

Living Situation: The patient lives with his wife.

Education Level: The patient has a high school diploma.

Admission Assessment

Chief Complaint (2 points): Weakness on extremities, left facial drooping, and slurred speech

History of present Illness (10 points):.

The patient is an 87-year-old male experiencing left side weakness on the extremities before exercising around 7720 on October 29, 2021. The symptoms progressed to left facial drooping, and slurred speech, and patient wife decided to call 911. The paramedics transported him to OSF Danville emergency room, where they evaluated him for stroke. ED doctor ordered 100 mg IV alteplase and 0.9% sodium chloride IV bolus on ED. After stabilizing, the patient was then transferred to the critical care unit of OSF Champaign.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Acute right middle cerebral artery (MCA) stroke

Secondary Diagnosis (if applicable): n/a

Pathophysiology of the Disease, APA format (20 points):

A cerebrovascular accident (CVA) or stroke happens when there is a sudden disruption of oxygen supply to the brain due to blockage or rupture of one or more blood vessels in the brain (Swearingen & Wright, 2019). There are three types of strokes. First, ischemic stroke happens when there is an obstruction in brain blood flow from thrombus or embolus (Capriotti, 2020). Second, hemorrhage stroke happens when there is bleeding in or around the brain due to blood vessels in the brain rupturing (Swearingen & Wright, 2019). Lastly, a transient ischemic attack is a disturbance of blood circulation on the brain that causes neurological deficit; however, it is reversible and only lasts for less than 24 hours (Capriotti 2020). The middle cerebral artery is the most common region affected by ischemic and hemorrhagic stroke (Capriotti 2020).

Signs and Symptoms vary depending on location in the brain and severity of the injury. Manifestation of stroke usually appears in the side of the body opposite the brain's damaged site, such as sudden numbness or weakness of the face, arm, and leg. Confusion, disorientation, memory loss, change in mental status are other signs and symptoms of stroke (Swearingen & Wright, 2019). In addition, the patient experiences facial drooping, extremities weakness, and speech difficulty, which are the most common sign and symptoms of a stroke (Capriotti, 2020). Elevated blood pressure and heart rate can manifest when having a stroke (Swearingen & Wright, 2019). The patient was experiencing elevated blood pressure and heart rate upon arrival to the ED.

The diagnostic tests to help diagnose stroke are CT scan and MRI. CT scan and MRI can show the location of infarction, bleeding in the brain, or abnormalities in brain structure (Swearingen & Wright 2019). The patient had a CT scan of the head and neck. The CT scan shows that the patient has a small aneurysm of the tip of the right internal carotid. No laboratory test diagnoses stroke. CBC, platelet count, INR, and prothrombin are laboratory tests used to determine if the patient is a potential candidate for thrombolytic therapy (Capriotti, 2020). The patient has an INR of 1.1 and PT of 3.0.

Capriotti (2020) states that rapid recognition of stroke is an integral part of treatment initiation. Ischemic stroke treatment is administering IV clot-buster medication called recombinant tissue-type plasminogen activator(rt-Pa). The medication rt-PA dissolves the clot blocking in the arteries in the brain and should be given within 3 to 4.5 hours of symptom onset. In addition, aspirin is given in the acute phase of ischemic stroke to decrease platelet aggregation and clot formation (Capriotti, 2020). The patient received 100 mg IV alteplase, and 50 mL IV bolus of 0.9% sodium chloride in the emergency department since the patient's symptoms started

one hour prior to arrival in the ED. The patient was transferred to the critical care unit of OSF Champaign after he was stable.

Pathophysiology References (2) (APA):

Capriotti, T. (2020). *Davis advantage for pathophysiology: Introductory concepts and clinical perspectives* (2nd ed.). F.A. Davis Company.

Swearingen, P. L., & Wright, J. D. (2019). *All-in-one nursing care planning resource medical-surgical, pediatric, maternity, and psychiatric-mental health* (5th ed.). Elsevier.

Laboratory Data (15 points)

CBC Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	4.40 – 5.80 10^6/mcL	3.91	4.08	Low RBC may be due to many factors such as anemia, destruction of RBC due to peripheral vascular atherosclerosis plaque, and hemorrhage (Pagana et al., 2020). The patient experienced CVA, and a CT scan showed atherosclerotic calcification seen on the right common carotid artery and right internal carotid artery.
Hgb	13.0 – 16.5 g/	11.5	11.7	Hgb reflects the number of RBCs in

	dL			the blood. Low Hgb may also be low RBC, destruction of RBC, and hemorrhage (Pagana et al., 2020). The patient experienced CVA and has a low RBC count.
Hct	38.0 – 50.0 %	34.2	35.7	Hematocrit is a percentage of red blood cells in an individual's blood, closely reflecting the Hgb and RBC count. Low Hct may also be low RBC count, low Hgb count, and hemorrhage (Pagana et al., 202). The patient has a low RBC and hemoglobin count.
Platelets	140 – 440 10^3/mcL	158	193	n/a
WBC	4.00 – 12.00 10^3/mcL	5.10	6.40	n/a
Neutrophils	40.0 – 68.0 %	60.7	74.0	Elevated neutrophil can associate with physical stress and trauma (Pagana et al., 2020) The patient had CVA which can cause physical stress and trauma
Lymphocytes	19.0 – 49.0 %	21.9	17.3	Decrease lymphocyte count is indicative of possible infection (Pagana et al., 2020) The patient was

				admitted for CVA and on the chart there is no noted infection going on to the patient which should be further investigated.
Monocytes	3.0 – 13.0 %	8.3	6.3	n/a
Eosinophils	0.0 – 8.0 %	2.1	1.6	n/a
Bands	0.0 – 5.0 %	n/a	n/a	n/a

Chemistry Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	**Normal Range**	**Admission Value**	**Today's Value**	**Reason For Abnormal**
Na-	133 – 144 mmol/L	134	141	n/a
K+	3.5 – 5.0 mmol/L	4.2	3.6	n/a
Cl-	98 -107 mmol/L	98	104	n/a
CO2	21 – 31 mmol/L	26	23	n/a
Glucose	70 – 99 mg/dL	101	81	Elevated Glucose may be due to acute stress response (Pagana et al., 2020) The patient had CVA which may cause a lot of stress in the body.

BUN	7 – 25 mg/dL	23	22	n/a
Creatinine	0.50 – 1.20 mg/dL	1.19	1.08	n/a
Albumin	3.5 – 5.7 g/dL	3.4	3.0	Low albumin may be due to many different factors such as cirrhosis, malnutrition, low protein diet, and fluid retention (Pagana et al., 2020). The patient has been experiencing edema in both hands since before being admitted. Also, the patient is not eating any protein during the stay in CCU.
Calcium	8.8 – 10.3 mg/dL	9.0	9.4	n/a
Mag	1.6 – 2.5 mg/dL	n/a	n/a	n/a
Phosphate	2.4 – 4.5 mg/dL	n/a	n/a	n/a
Bilirubin	0.2 – 0.8 mg/dL	0.5	n/a	n/a
Alk Phos	34 – 104 u/L	195	153	Elevated alkaline phosphate may be due to many different factors such

				as cirrhosis, blockage bile duct, and healing fractures (Pagana et al., 2020). The patient recently had a left hip fracture and underwent surgery two weeks before hospitalization. The elevated alkaline phosphate may be due to the healing fracture.
AST	13 – 39 U/L	32	27	n/a
ALT	7 – 52 U/L	12	8	n/a
Amylase	30- 110 U/L	n/a	n/a	n/a
Lipase	0 -160 U/L	n/a	n/a	n/a
Lactic Acid	0.5 – 2/2 mEq/L	n/a	n/a	n/a
Troponin	0.000 – 0.040 ng/mL	0.057	n/a	Elevation of troponin indicates myocardial injury or infarction. Elevation of troponin I can often be seen with ischemic stroke patients (Pagana et al., 2020). The patient had CVA.
CK-MB	0.000 – 0.030	n/a	n/a	n/a

	ng/mL			
Total CK	30 – 223 intlU/L	n/a	n/a	n/a

Other Tests Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	**Normal Range**	**Value on Admission**	**Today's Value**	**Reason for Abnormal**
INR	0.8 – 1.1	1.1	n/a	n/a
PT	10.1 – 13. 1 seconds	13.0	n/a	n/a
PTT	25 -36 seconds	33	n/a	n/a
D-Dimer	< 0.4 mcg/ mL	n/a	n/a	n/a
BNP	< 100 pg/mL	n/a	n/a	n/a
HDL	> 40 mg/dL	28	n/a	Low HDL may be due to many different factors such as excess weight, genetic factors, poor diet, and physical inactivity life (Pagana et al., 2020). The patient's low HDL may be due to familial HDL deficiency or poor diet.
LDL	< 130 mg/dL	89	n/a	n/a
Cholesterol	< 200 mg/dL	136	n/a	n/a

Triglycerides	< 150 mg/dL	93	n/a	n/a
Hgb A1c	4 – 5.6 %	n/a	n/a	n/a
TSH	0.4-4 mU/L	n/a	n/a	n/a

Urinalysis Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
Color & Clarity	Yellow & Clear	n/a	n/a	n/a
pH	4.6 – 8	n/a	n/a	n/a
Specific Gravity	1.005 – 1.03	n/a	n/a	n/a
Glucose	Negative	n/a	n/a	n/a
Protein	0 – 8 mg/dL	n/a	n/a	n/a
Ketones	Negative	n/a	n/a	n/a
WBC	0 – 4	n/a	n/a	n/a
RBC	< 2	n/a	n/a	n/a
Leukoesterase	Negative	n/a	n/a	n/a

Arterial Blood Gas Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
pH	7.35 – 7.45	n/a	n/a	No labs
PaO2	80 – 100 mm	n/a	n/a	No labs

	Hg			
PaCO2	35 – 45 mm Hg	n/a	n/a	No labs
HCO3	21 – 28 mEq/L	n/a	n/a	No labs
SaO2	95 – 100%	n/a	n/a	No labs

Cultures Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Test	**Normal Range**	**Value on Admission**	**Today's Value**	**Explanation of Findings**
Urine Culture	Negative	n/a	Negative	Urine culture is done to determine the presence of any pathogenic bacteria in the patient's urine (Pagana et al., 2020). There were no foreign microorganisms present in the patient's urine.
Blood Culture	Negative	n/a	n/a	No labs
Sputum Culture	Negative	n/a	n/a	No labs
Stool Culture	Negative	n/a	n/a	No labs

Lab Correlations Reference (1) (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2020). *Mosby's diagnostic and laboratory test reference* (15th ed.). Elsevier.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

- CT Head/Brain (stroke protocol) (10/29/2021)
- CTA Head & Neck without contrast (10/29/2021)
- XR Chest (10/29/2021)
- EKG (11/29/2021)
- XR Swallowing function study (11/01/2021)

Diagnostic Test Correlation (5 points):

- CT of the Head/Brain (stroke protocol) The patient experiecing facial drooping and slurred speech. The purpose of CT of the Head/Brain was to visualize the head and brain for cerebral infarction, cerebral aneurysm, intracranial hemorrhage, and hematoma (Pagana et al., 2020)

  Result: Possible small aneurysm of the tip of right internal carotid
- CTA of the Head and Neck without contrast: Patient suspects of acute CVA. The purpose of CTA of the Head and neck was to visualize the blood vessel and carotid artery in the head and neck to help evaluate for aneurysms or blockages (Pagana et al., 2020).

  Result: Atherosclerotic calcification seen on right common carotid artery and right internal carotid artery. 50-60% narrowing of the proximal right internal carotid.
- XR Chest: Patient experienced chest pain and to evaluate for aspiration. The purpose of a chest x-ray to visualize the heart and lungs for any problems (Pagana et al., 2020)

  Result: Calcification seen on aortic arch; cardiomegaly and pacemaker noted.

- Electrocardiogram: Patient suspects of cerebrovascular accident (CVA). The purpose of EKG was to visualize the electrical impulse that the heart generates during the cardiac cycle. In addition, identify any abnormal heart rhythms (Pagana et al., 2020). In addition, to identify if stroke causes any heart rhythm problem.

  Result: ventricular paced rhythm
- XR swallowing function study: Patient diagnosed with acute MCA stroke with facial droop and symptoms of aspiration. The purpose of this XR swallowing function study is to identify problems that exist in ap patient unable to swallow (Pagana et al., 2020)

  Result: Thick liquid was swallowed without aspiration. Aspiration with delayed cough seen with thin and nectar liquid.

Diagnostic Test Reference (1) (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2020). *Mosby's diagnostic and laboratory test reference* (15th ed.). Elsevier.

Current Medications (10 points, 1 point per completed med)
10 <u>different</u> medications must be completed

Home Medications (5 required)

Brand/Generic	Coreg/	Flomax/	Pravachol/	Ventolin	Ativan/

	carvedilol	tamsulosin	pravastatin	HFA/ albuterol sulfate	lorazepam
Dose	3.125 mg	0.4 mg	20 mg	Two puffs	0.5 mg
Frequency	2x daily	Daily	Daily	PRN	PRN
Route	Oral	Oral	Oral	Inhalation	Oral
Classification	Nonselective beta blocker and alpha-1 blocker/ Antihypertensive	Alpha adrenergic antagonist/ BPH agent	HMG-CoA reductase inhibitor/ Antilipemic	Adrenergic/ bronchodilator	Benzodiazepine/ anxiolytic
Mechanism of Action	This medication reduces cardiac output and tachycardia, causes vasodilation, and decreases peripheral vascular resistance.	This medication block $alpha_1$-adrenergic receptors in the prostate which inhibit smooth muscle contraction.	This medication inhibits cholesterol synthesis in liver by blocking the enzyme need to convert HMG-CoA to cholesterol precursor.	This medication attaches to $beta_2$ receptors on bronchial cell membrane to relax the bronchial smooth muscle.	This medication potentiates the effect of GABA which inhibits excitatory stimulation helping control emotional behavior
Reason Client Taking	To control hypertension	To treat benign prostatic hyperplasia	To treat hyperlipidemia	For wheezing	For anxiety
Contraindications (2)	Any bronchospastic condition Third degree AV block	Hypersensitivity to tamsulosin. Prostate cancer	Unexplained or persistent elevated liver enzymes Hypersensitivity to pravastatin	Hypersensitivity to albuterol or its components; severe cardiac disorders	Acute angle-closure glaucoma Hypersensitivity to lorazepam and its components
Side Effects/Adverse Reactions (2)	Bradycardia Heart failure	Arrhythmia Atrial fibrillation	Hemolytic anemia Hepatic failure	Angina Arrhythmias	Respiratory depression confusion
Nursing Considerations (2)	Monitor blood glucose level because the	Before taking this medication therapy, be	Monitor liver enzyme before and during	Use cautiously in patient with cardiac	Use extreme caution when giving lorazepam to

	medication may alter blood glucose level. Monitor intake and output ratios and daily weight	sure that prostate cancer was ruled out. Give medication about 30 minutes after the same meal each day.	therapy. Monitor blood lipoprotein level to evaluate effectiveness of medication	disorders and hypertension because albuterol can worsen these conditions. Patient can develop tolerance to albuterol with prolong use.	elderly patient and those who have compromised respiratory function because it can cause hypoventilation. Monitor patient respiration every 5 to 15 minutes
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Assess patient vital sign and blood glucose. Review, glucose, BUN, and creatinine level	Assess patient vital sign and blood pressure because this medication can cause hypotension. Monitor for any electrolyte imbalance.	Assess patient for any weakness and unexplained muscle ache. Monitor liver enzyme, BUN, creatinine, and lipoprotein level.	Assess patient respiratory status. Monitor potassium level because it can cause transient hypokalemia	Assess patient respiratory status. Review CBC and liver function test.
Client Teaching needs (2)	Warn patient that drug may cause dizziness, lightheadedness, and orthostatic hypotension. Tell patient to notify provider if they gain 5 lbs. or more in 2 days or if shortness	Advise patient to change position slowly to minimize effects of orthostatic hypotension. Instruct patient to not crush or chew medication and take 30	Instruct patient to take this medication at bedtime. Advise patient to notify provider if experiecing any muscle pain, tenderness, and weakness	Teach patient to wait at least 1 minute between inhalation if dosage requires more than one inhalation. Advise patient to consult prescriber	Instruct patient to take this medication precisely as prescribed and not stop abruptly. Advise patient to avoid hazardous activities until they know CNS

	of breath increases which may signal worsening heart failure	minutes after same meal each day.	when taking this medication.	before using other inhaled drugs and not to exceed prescribed dose or frequency.	effect to them

Hospital Medications (5 required)

Brand/Generic	Aspirin/ acetylsalicylic acid	Plavix/ clopidogrel	Protonix/ pantoprazole	Aldactone/ spironolactone	Prinivil/ lisinopril
Dose	81 mg	75 mg	40 mg	12.5 mg	5 mg
Frequency	Daily	Daily	Daily	Daily	Daily
Route	Oral	Oral	Intravenous	Oral	Oral
Classification	Salicylate/ NSAID/ antiplatelet	$P2Y_{12}$ platelet inhibitor/ Platelet aggregation inhibitor	Proton pump inhibitor/ antiulcer	Potassium-sparing diuretic/ diuretic	ACE inhibitor/ antihypertensive

Mechanism of Action	This medication inhibits the activity of the enzyme (COX) which leads prostaglandins formation that cause inflammation, swelling, pain and fever. Inhibit platelet aggregation by inhibiting production of thromboxane A2.	This medication binds to adenosine diphosphate (ADP) receptors on the surface of activated platelets.	This medication interferes with gastric acid secretion by inhibiting the hydrogen-potassium-adenosine triphosphatase in gastric parietal cells	This medication blocks the action of aldosterone resulting in potassium retention and the excretion of sodium and water	This medication may reduce blood pressure by inhibiting conversion of angiotensin I to angiotensin II.
Reason Client Taking	To prevent clot formation and reduce risk of stroke	Prevention of recurrent stroke.	For GERD	For heart failure and edema	To treat hypertension
Contraindications (2)	Active bleeding Hypersensitivity to aspirin or its components	Intracranial bleeding Hypersensitivity to clopidogrel	Hypersensitivity to pantoprazole Kidney inflammation	Anuria Hyperkalemia	Idiopathic angioedema Renal impairment
Side Effects/Adverse Reactions (2)	Hepatotoxicity Prolong bleeding time	Bronchospasm Unusual bleeding	Hepatotoxicity C. diff associated diarrhea	Hypotension Leukopenia	CVA Acute renal failure
Nursing Considerations (2)	Do not crush time-released or controlled aspirin tablet. Monitor patient for	Monitor patient who concurrent use aspirin for bleeding. Be aware that medication	Flush IV line with lactated ringers' injection before and after giving medication Give	This medication can be crushed for patient who have difficulty swallowing	Monitor patient for hepatic dysfunction Monitor blood pressure often during

	manifestations of gastric bleed such as coffee-ground emesis or bloody, tarry stools.	have prolong bleeding time, expect to stop 5 days before any surgery	medication over 2 minutes with 10 ml of normal saline injection	. To evaluate effectiveness, assess patient blood pressure and presence of edema	the first 2 weeks of therapy.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Assess for sign of bleeding. Review CBC, platelet lab value	Assess vital sign/ blood pressure. Review CBC especially platelet count.	Assess patient urine output because it may be a sign of acute interstitial nephritis. Review PT and INR because this can increase bleeding risk.	Assess vital sign/blood pressure and edema. Monitor serum potassium level	Assess blood pressure. Review creatinine and potassium lab
Client Teaching needs (2)	Take aspirin with food or after meal and a full 8 oz glass of water every day. Advise patient not to also take ibuprofen because it may reduce stroke preventative effect of aspirin	Instruct patient to not stop use of medication abruptly without addressing to provider. Educate patient about informing other HCP about the medication use including dentist due to increased risk of bleeding	Advise patient to expect relief of symptoms within 2 weeks of use. Advise patient to notify provider if they experience decrease urine output because it may be a sign of acute interstitial nephritis	Take this medication with meals or milk. Teach patient to measure blood pressure regularly and report any systolic pressure greater than 150 mm Hg or diastolic pressure 90 mm Hg	Advise patient to take medication at the same time everyday Inform patient that persistent nonproductive cough may develop.

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2020). *2020 nurse's drug handbook* (19th ed.). Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL (1 point):	
Alertness:	Alert and responsive
Orientation:	Oriented to person, place, time, situation.
Distress:	No acute distress
Overall appearance:	Appropriately dress, well-groomed
INTEGUMENTARY (2 points):	
Skin color:	Usual for ethnicity
Character:	Skin dry and intact
Temperature:	Warm to touch
Turgor:	Elastic turgor
Rashes:	No rashes
Bruises:	Stage 1 pressure injury in the coccyx
Wounds: .	No wounds
Braden Score:	Braden score 11
Drains present: Y☐ N ☒ **Type:** n/a	No drain present
HEENT (1 point):	
Head/Neck:	Normocephalic, left facial drooping noted. Palpable thyroid cartilage, no tracheal deviation, no palpable lymph nodes, 2+ carotid pulse bilaterally
Ears:	Gray tympanic membranes bilaterally, auricle pinna are intact. Hard hearing
Eyes:	Pupils are equal, round, reactive to light, and accommodate, white sclera & conjunctiva, intact extraocular movements. Wear glasses.
Nose:	Bilateral patency, no discharge, no frontal or maxillary sinus pain
Teeth:	Pink, moist, firm gingiva

	Pink, moist buccal mucosa Rise and fall of soft palate, symmetrical uvula**.** .
CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☒ N ☐** **Location of Edema:** Bilateral hands	 S1, S2 clear with no murmur. No friction rubs or gallop. Heart rate: 70 Rhythm: Regular P waves: One present for every QRS PR interval: 0.16 second QRS width: 0.08 seconds Interpretation: Normal sinus rhythm, ventricular paced rhythm Pulses: 2+ radial and posterior tibial bilaterally <3 seconds No neck vein distention Edema: +2
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character** **ET Tube:** n/a **Size of tube:** n/a **Placement (cm to lip):** n/a **Respiration rate:** n/a **FiO2:** n/a **Total volume (TV):** n/a **PEEP:** n/a **VAP prevention measures:** n/a	No accessory muscle use Respiratory rate and pattern: Regular Respiratory sounds: diminished in all lobes anteriorly and posteriorly. Lung aeration: Equal in all lobes anteriorly and posteriorly No ET tube
GASTROINTESTINAL (2 points): **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:**	 Normal diet Pureed diet and honey consistency 175.3 cm 83.1 kg Hypoactive bowel sound in all four quadrants 01/02/2021 No tenderness, mass, or pain, and guarding. Soft and non-distended No noted distention No noted incision No noted scars No noted drains No noted wounds

Ostomy: **Y** ☐ **N** ☒ **Nasogastric:** **Y** ☐ **N** ☒ **Size:** n/a **Feeding tubes/PEG tube** **Y** ☐ **N** ☒ **Type:** n/a	
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination:** **Y** ☐ **N** ☒ **Dialysis:** **Y** ☐ **N** ☒ **Inspection of genitals:** n/a **Catheter:** **Y** ☐ **N** ☒ **Type:** n/a **Size:** n/a **CAUTI prevention measures:** n/a	 Yellow Clear 75 mL
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance:** **Y**☒ **N** ☐ **Fall Risk:** **Y** ☒ **N**☐ **Fall Score:** 55 **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk**☐	 Pink nailbeds, cap refill <3 seconds, warm extremities Impaired active ROM in left upper and lower extremities Hearing aids and walker Weakness noted on left side Patient on bed rest and turned every 2 hours.
NEUROLOGICAL (2 points): **MAEW:** **Y** ☒ **N**☐ **PERLA:** **Y** ☒ **N**☐ **Strength Equal:** **Y** ☐ **N** ☒ **if no -** **Legs** ☐ **Arms** ☐ **Both** ☒ **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	 Oriented to person, time, place, and situation. Negative for altered mental status. Normal cognition Slurred speech Light and deep stimuli response Alert, awake and answer question appropriately
PSYCHOSOCIAL/CULTURAL (2 points):	.

Coping method(s):	Patient likes to listen to worship song and watch television.
Developmental level:	Appropriate for age. No noted deficit. Capable of deciding for self.
Religion & what it means to pt.:	The patient religion is Assembly of God and believes in God. He used to lead music at church
Personal/Family Data (Think about home environment, family structure, and available family support):	The patient lives with wife. Wife does most of the cooking and cleaning of the house with the help of their daughter sometimes. His wife and daughter were his family support and both present during care.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0730	69 bpm	110/62 mm Hg	16 bpm	97.7 F (temporal)	97% room air
1130	70 bpm	112/60 mm Hg	18 bpm	98 F (temporal)	98% room ai

Vital Sign Trends/Correlation: The patient's vital signs are within normal limits and stable—no noted notable sudden decrease or increase in value within the two sets of vital signs.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0830	Numeric	coccyx	10/10	"Sore, pressure, and aching"	Gave 650 mg acetaminophen PO
1130	Numeric	coccyx	5/10	"pressure"	Repositioned patient

IV Assessment (2 Points)

IV Assessment	**Fluid Type/Rate or Saline Lock**
Size of IV: 22G **Location of IV:** right cephalic vein **Date on IV:** 10/29/2021 **Patency of IV:** Patency is verified by flushing 10 ml of normal saline flush. **Signs of erythema, drainage, etc.:** No sign of erythema, drainage, swelling or tenderness. **IV dressing assessment:** clean, dry, and intact	Saline lock
Other Lines (PICC, Port, central line, etc.)	
Type: n/a **Size:** n/a **Location:** n/a **Date of insertion:** n/a **Patency:** n/a **Signs of erythema, drainage, etc.:** n/a **Dressing assessment:** n/a **Date on dressing:** n/a **CUROS caps in place: Y** ☐ **N** ☐ n/a **CLABSI prevention measures:** n/a	N/A

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
20 mL – normal saline flush 150 mL – tomato juice 120 mL – apple sauce	75 mL – urine 1 stool

Nursing Care

Summary of Care (2 points)

Overview of care: Administer medication, check vital sign check, and completed physical assessment.

Procedures/testing done: The patient did not have any tests completed on 11/02/2021.

Complaints/Issues: Patient complains scale of 10/10 pain on coccyx area. The patient defined the pain as “sore, pressure and aching.”

Vital signs (stable/unstable): The patient’s vital signs are within normal limits and stable—no noted notable sudden decrease or increase in value within the two sets of vital signs.

Tolerating diet, activity, etc.: The patient is on a pureed diet and ordered tomato juice and apple sauce for breakfast. The patient is on bedrest.

Physician notifications: Patient will still stay in the unit and continue medication. No changes in status or abnormal lab values

Future plans for patient: The patient will be discharge to an inpatient rehabilitation facility.

Discharge Planning (2 points)

Discharge location: They are still looking for an inpatient rehabilitation facility to transfer patient.

Home health needs (if applicable): PT, OT, and home health nurse

Equipment needs (if applicable): n/a

Follow up plan: Follow up with physician.

Education needs: Education about all medication needs to be taken after discharge—ensuring patient will be compliant, lifestyle modification, and therapy option.

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components	**Rational** • Explain why the nursing diagnosis was chosen	**Intervention (2 per dx)**	**Evaluation** • How did the patient/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Risk for aspiration related to severe oropharyngeal weakness secondary to stroke as evidenced by impaired swallowing ability and swallowing function test result of aspiration with delayed cough with thin and nectar liquid.	Ensuring maintaining the airway is the highest priority. The patient has impaired swallowing, which increases his risk for aspiration.	1. Keep HOB elevated during meals and after meal. 2. Provide oral hygiene after meal.	Goal: free of signs of aspiration prior to discharge. When the patient is eating, we ensure that the HOB is elevated. The nurse provides oral hygiene after his meal. The status of the goal is ongoing.
2. Acute pain related to stage 1 pressure injury in the coccyx as evidenced by patient reporting experiencing "aching, sore, pressure pain in the coccyx area and pain scale of 10/10."	Acute pain is a high priority. The patient is experiencing pain in his coccyx area constantly.	1. Gave 650 mg acetaminophen PO. 2. Repositioned patient every 2 hours	Goal: The patient will be comfortable or free of pain prior to discharge. We gave the patient 650 mg acetaminophen when he reported a pain rate of 10/10. Around 1130 his pain rate was 5/10, so we repositioned him to his side so that he doesn't feel any pressure in his coccyx that can aggravate pain. The status of the goal is ongoing.
3. Risk for fall related to high	The patient is at risk of fall due	1. The patient fall wristband	Goal: The patient will not sustain fall prior to

fall risk assessment evidence by Morse fall score of 55.	weakness and decreased muscle strength secondary to CVA.	identification and bed alarm is on. 2. Move items such as call light, and telephone near to patient to reach easily.	discharge. The patient bed alarm is on. The patient know he needs to call his nurse if he needs anything. This nursing student and nurse ensure that items used by the patient is within the patient reach. The status of the goal is ongoing.
4. Unilateral neglect related to CVA evidence by decrease strength on left side upper and lower extremities.	The patient is experiencing left side neglect due to the CVA effect on the right of the brain, and nurses observe he is having a hard time moving his left side.	1. Make sure side rails are up on the bed 2. Arrange necessary object such as call light and phone on the patient unaffected side	Goal: The patient will be free from injury prior to discharge. The patient's two side rails are up all the time. The patient call light and phone are on the table near him on his right side. The status of the goal is ongoing.
5. Risk for decrease functional ability related to slight weakness of patient evidence by decreased muscle strength.	The patient is experiencing generalized slight weakness and decrease muscle strength was noted	1. Assist patient with exercise and perform ROM exercises 2. Referral for PT and OT	Goal: Increase or improve the muscle strength of the patient prior to discharge. The patient was encouraged to do some exercise and ROM exercises. The status of the goal is ongoing.

Other References (APA):

Swearingen, P. L., & Wright, J. D. (2019). *All-in-one nursing care planning resource medical-surgical, pediatric, maternity, and psychiatric-mental health*. Elsevier.

Vera, M., (2020, May 13). *1,000+ Nursing Care Plans: The Ultimate Guide and Database for Free*. Nurselabs. from https://nurseslabs.com/nursing-care-plans/

Concept Map (20 Points):

Subjective Data

The patient was experiencing weakness on the left side extremities, slurred speech, and facial drooping.
During the stay, verbalize having difficulty swallowing
Pain scale 10/10 in the coccyx area. Describe the pain as "sore, pressure and aching."

Nursing Diagnosis/Outcomes

Risk for aspiration related to severe oropharyngeal weakness secondary to stroke as evidenced by impaired swallowing ability and swallowing function test result of aspiration with delayed cough with thin and nectar liquid.
Goal: free of signs of aspiration prior to discharge.
Acute pain related to stage 1 pressure injury in the coccyx as evidenced by patient reporting experiencing "aching, sore, pressure pain in the coccyx area and pain scale of 10/10."
Goal: The patient will be comfortable or free of pain prior to discharge.
Risk for fall related to high fall risk assessment evidence by Morse fall score of 55.
Goal: The patient will not sustain fall prior to discharge.
Unilateral neglect related to CVA evidence by decrease strength on left side upper and lower extremities
Goal: The patient will be free from injury prior to discharge.
Risk for decrease functional ability related to slight weakness of patient evidence by decreased muscle strength.
Goal: Increase or improve the muscle strength of the patient prior to discharge.

Objective Data

Assessment finding:
Impaired active ROM in left upper and lower extremities.
Slurred speech and left facial drooping
Imaging
CT scan of Brain and head: small aneurysm of the tip of right internal carotid. Atherosclerotic calcification of right common carotid artery.
XR swallowing function study: aspiration with delayed cough with thin and nectar liquid
Labs
RBC: 4.08
Hgb: 11.7
Hct: 35.7
Neutrophil: 74. 0
Lymphocytes: 17.3
Glucose: 101
Alk Phos: 195
Troponin 0.057
HDL: 28
Vital signs are within normal range.

Patient Information

An 87-year-old White Caucasian male with a history of complete heart block with pacemaker placed, COPD, arteriosclerotic heart disease, hypertension, hyperlipidemia, and coronary angioplasty with stent placement admitted to CCU due to acute right MCA stroke

Nursing Interventions

Keep HOB elevated during meals and after meal.
Provide oral hygiene after meal.
Gave 650 mg acetaminophen PO.
Repositioned patient every 2 hours
The patient fall wristband identification and bed alarm is on.
Move items such as call light, and telephone near to patient to reach easily.
Make sure side rails are up on the bed.
Arrange necessary object such as call light and phone on the patient unaffected side.
Assist patient with exercise and perform ROM exercises.
Referral for PT and OT.